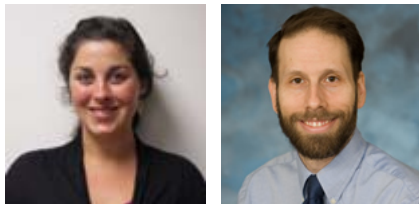


Camden Coalition's Model for High Needs Patients

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There is a lot of buzz about reducing hospital readmissions. But what does a readmission look like? And what will it take to provide the care needed to avoid readmissions?

We arrived at the ICU to find our patient sedated and intubated. Yet only 10 days earlier Mrs. P was strong enough to navigate the halls in her wheel chair, had her diabetes and COPD under control and was taking her medications for bipolar disorder. Mrs. P was discharged with an abundance of home health services – nursing, physical therapy, occupational therapy, home health aid. How had her condition declined so quickly?

We visited her on day three post-discharge. Mrs. P was in her living room hospital bed covered in her own body fluids unable to turn herself. We helped her husband clean her, dress her, and move her into a position where her lungs had a chance to fully expand. We also checked her blood sugar – slightly over 250. The rehab center had discharged her with sliding scale insulin and believed that her elderly husband knew how to administer it. However, when we asked him to try, he only pulled up air into the syringe. He was not strong enough or organized enough to take care of Mrs. P's incredibly demanding health needs which required over 10 medications, multiple monthly doctors visits, special transportation, and help with daily living activities. A 4-day lag in her home health agency opening her case was enough time for Mrs. P's health status to go from good to seriously troubled.

Mrs. P's experience wasn't a new one. The ICU stay was her third admission to the hospital in the last three months. Initially she had been hospitalized for a COPD exacerbation, sent to rehab, discharged home for several hours before a decline that required another hospital admission and then she repeated this cycle. She was frustrated. Her family was frustrated. And we were frustrated as we watched her careen between the

best healthcare Camden has to offer and near neglect of her health needs. The reasons for the cycle are complex with her greatest complication being our fragmented health system. During her hospital and rehab stays her health improved because she was receiving daily assistance with her complicated medication regime. Following discharge her inability to use her glucometer, administer insulin, and understand her medications left her vulnerable to rapid health decline. Since her admissions began, she had been disconnected from primary care and getting her into a new primary care doctor would take weeks. As her husband battled his own health problems, she needed more assistance at home but did not qualify because her Medicaid application is only just started.

Mrs. P's suffering is also costly. During the last three months, Medicare paid over \$73,000 for Mrs. P's 3 admissions, including 2 ICU stays, and 11 weeks of rehab. Preventing her third readmission alone would have saved Medicare \$19,482. Then there is the cost to Mrs. P and her family. She kept losing the good health she would gain in rehab. Her husband felt guilty and embarrassed that he could not provide the expert care his wife needed to stop cycling in and out of the hospital. Sadly, Mrs. P. is not alone in her struggles to stay healthy and out of the hospital. Everyday in the United States, 10,000 more people turn 65 and many will suffer with multiple chronic illnesses, trouble with transportation, and questions regarding what level of care they truly need. This population will bill Medicare with its expenses and overburden families with its home health needs.

To break the hospitalization cycle and to curb healthcare spending, the Camden Coalition of Healthcare Providers has developed an innovative care management model for high needs / high costs patients in Camden NJ. The Care Management Team relies on home visits with patients to coordinate doctors' appointments, transportation, and social services. The Team provides holistic medical care as well as root cause analysis and solutions to the often intertwined issue of poverty and disease that plague its patients. At any given time the Team sees approximately 35-40 patients.

We are often asked why we work so intensely on a hand-full of patients. From analyzing data gathered from three hospitals in Camden, we found that 1 percent of patients account for 30 percent of costs. If we focus on the heaviest utilizers of health care, connect them into primary care, and address their needs outside of hospitals, we can begin to bend the cost curve. The numbers are convincing and inform our overarching mission. But every day we also see the faces of patients needing assistance. It is our patients' confrontation with or neglect from our fragmented, difficult to navigate healthcare system that fuels the change we are trying to make.

The Care Management Team has seen great success with many patients. For Mrs. P., we ensured home health arrived soon after her discharge from this ICU stay and continued to communicate with them. We connected her to a new primary care doctor and arranged transportation to her appointments. We involved her family in a discussion about long term goals and are facilitating her entry into an adult day program. For other patients, we've supported them to achieve permanent housing, affordable medications, and primary and specialty care appointments with doctors who they trust. Yet, we realize that

time-intensive care management often falls into the laps of ill-equipped, overburdened primary care providers, hospital residents or insurance companies.

The Coalition is working to supply providers with tools to reduce the time and cost associated with great care coordination. The Coalition has developed the Camden Health Information Exchange (HIE) to coordinate the hospital discharge summaries, lab data, and radiology reports for Camden residents. The Camden HIE allows providers to have up-to-date information on their patients' conditions and eliminates the need to order repeat tests. We also are positioning Care Coordination Teams in Camden primary care offices. The Teams will focus on patients with diabetes or high health care utilization for whom extra care coordination support is needed.

As we look to the future, working in a more coordinated fashion is the only way that the needs of our growing, aging population will be met in the United States. In Camden, we are testing models to improve health care and social services navigation, reduce unnecessary utilization, and equip providers with health information and coordination teams. If we can support patients in their efforts to attain good health, we will decrease costs and be able to provide more and higher quality services for all.

The Camden Coalition of Healthcare Providers (www.camdenhealth.org) was created with the overarching mission to improve the health status of all Camden, NJ residents, by increasing the capacity, quality, and access of care in the city.

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